The Farmer and The Cowhand

Referrals and Outcomes work between SEA and South CAT 2007-2012

a report for the monitoring group for South East Alternatives, Glasgow

February 2012.1

Referrals and Outcomes

working with each other to co-create a community rehab fit for the community.

Staying behind the barricades and lobbing bricks at each other was one of the images that came to my mind when I first heard the mutual complaints of the CAT of the Community Rehab staff and the Community Rehab staff of the CATS in mid 2007.

The blame for poor referral rates and poor programme take up rates was thrown back and forth; "the Community Rehab programme was rubbish" "the CAT sent woefully inappropriate referrals". The blame ball passed back and forth. Management had intervened on both sides; on the one with instructions to refer and on the other with instructions to accept all referrals unquestioningly.

The blame game had to stop somewhere.

Fortunately with a new manager in the Community Rehab, there was a willingness to begin again. Old relationships were helpful here. As the new manager for SEA, some of the CAT staff cut me some slack based on previous knowledge of my work from earlier postings. Knowing them from the old days, I was really open to hearing what their experience had been of SEA.

The unwillingness to refer was simple: they had no faith in the programme and its ability to keep people safe from illicit drug use on the project premises. On the other side, the rehab staff had some very positive relationships with CAT staff, but felt easily blamed for programme participants failures and at times unsupported by the referring Care Manager from CAT.

These complaints provided real grist to the mill of the SEA service redesign; we knew what was wrong and what we all wanted to change. We knew a change in referral rates would be an early indicator of some success in re-building relationships between the teams.

The Glasgow Community Rehab Review 2008- DATA!

The Glasgow Community Rehab Review in 2008 pointed out many of the ways in which SEA was progressing and one very glaring area where it's efforts at change were being seriously let down: that was the management of the data and referrals.

Our data returns rarely added up. We were only at the beginning of a long slog to rehabilitate our referral relationships.

Kim Ross and Kuladharini, TPS Service Managers at the very first UK Recovery Walk in Liverpool.

In the midst of the project's recovery from a serious and prolonged decline, it was clear that the very simple data demands of funders needed to be met, consistently and accurately. We could not know how successful (or not) we were if the numbers did not add up!

Referrals? 2006/7

We also faced a serious challenge at the beginning of the project transformation; we were getting few referrals from the very CATs the project was designed to serve. In 2006/7 there were 68 referrals in the whole year from the two local CATs (South and South East) whose combined case load ran in the thousands. In the same year there were 144 self referrals which was suggested indicated a positive motivation on the part of individuals in the community. We will explore the issue of self referrals later.

Prior to the appointment of the new service managers for SEA and Milestone in 2007, the approach to referrals at SEA was to feel under pressure to take everyone who presented. Numbers of referrals were, at the time, one of the few yardsticks used for measuring the effectiveness of community rehab.

The staff were told; take them, we need to fill this programme. This is understandable. However, such a "zero criteria" approach to joining a community rehab programme was a bit like pouring petrol on the fire of the project's decline.

With no effective criteria and expectations; the levels of challenging behaviour grew, with no outcomes there was no way to measure when the community rehab had finished its work with an individual and no way to know if the person was ready to begin. So in May 2007, when I joined the staff, there were 70 names on the board but scarcely a dozen people turning up regularly for group programmes.

Action on Referrals and Outcomes- 2007

The problems were identified after a good few conversations between South CAT team members and the new service manager. They clustered around poor reputation, poor relationship and a lack of clarity about what the service did.

Some of the immediate remedial actions taken by SEA and South CAT.

1. Clarified criteria and outcomes for each phase of the programme.

2. Open House Project visit weekly (Referrers to personally bring people they are referring to first visit) Stopped the time wasting individual project visit.

3. Joint management meeting with CAT fortnightly.

4. Created project leaflet

5. Found a means for regular contact between the teams. (joint research project in stationing a SEA project worker in CAT clinic for 3 weeks/ joint minority ethnic pre-programme)

6. Have an appointment for assessment within a week of visit for people referred.

Referrals for 2007/ 2008 increased to 396 for the year. South CAT referrals in particular more than doubled to 189. The other (self and other service) referrals also rose to 156. Though by this stage we were doubting the efficacy of many of these "self/other" referrals as very few people from homelessness services made it onto the programme. In five years no-one direct from GDCC / Link UP or other homeless service referral route has completed the whole programme. By year 2 of this work we started to ask questions about these and self referrals.

Researching our collective assumptions about referrals

After we had cleaned up and redesigned our programme, we worked with the South/ South East CAT to explore some of the assumptions we both made about the referrals to the service:

- It was assumed that people's territorialism would affect their ability to attend a programme in the Gorbals (if they lived in castlemilk).
- It was assumed that ethnicity and being the only non-white face may have a negative effect of attendance at community rehab from those referring from the minority ethnic service.
- It was assumed that women would be held back by the lack of creche.
- It was assumed that an embedded Community rehab worker in the CAT team at clinic times would improve assessment rates.
- It was assumed that a Castlemilk based programme would mean greater attendance at Community rehab from people from Castlemilk.

The joint work of researching having an embedded Community Rehab worker showed that it did not increase referrals at all at the point of the embedded worker. During our 3 weeks of having CR staff available at the CAT clinics we got only two new programme referrals that way. However what it did do was increase the normal referrals to SEA. The very fact of getting to know each other through this short embedding built some trust in the newly developing programme at SEA . CAT staff referred using normal routes in increasing numbers during this time and continued to do so after the experimental embedding ended.

The same happened with the Castlemilk programme experiment. Only a handful of people referred into the Castlemilk experiment but many more from Castlemilk started to attend the Gorbals programme during the exact same time!

Women were not generally held back from attending recovery programme by lack of creche. Flexibility in managing attendance during school holidays, doing extended 121 support with lots of homework and shared sponsoring of nursery places with CAT meant that the rates of women on the programme improved. Improving the environment at SEA had a big effect on retention rates of women. Making the programme rooms beautiful and safe had the biggest effect on women. To this day men notice staff and participant friendliness as the ease creating factor on first contact with SEA and women describe the beauty of the environment as the main ease creating factor.

A joint pre-entry programme with the minority ethnic addiction team showed that we did not need such a specialist pre -programme. What we needed was a clear recovery direction. The SEA staff interviewed many of the individuals available through this specialist team and found that what was happening was a failure of hope not a failure of human relations between ethnic groups. The work made us more confident of our approaches. Steadily with recovery helping people regain hope for the future, we found we had good involvement across ethnic groups.

We found NO territorial problems once CAT workers attended the visit with the person they were referring. What had been taken as territorialism was just simply social anxiety; easily overcome by going with their care manager and being properly introduced to SEA.

Once at SEA, the change in the relationship management meant that the individual referred only told their story once at assessment . The assessing worker became their key worker. Assertive case management and follow up by their SEA key worker meant more people securely tied into SEA before they ever approached a group setting. Consistent weekly hour long 121 work throughout the year long programme means everyone has a place for material that they do not wish to share in group. Everyone has a primary relationship with a key worker that stays the same throughout the whole programme. It is this key worker who witnesses and rejoices in their recovery achievements at reviews and in front of their families at graduation.

Adoption of Recovery orientation and Abstinence outcomes

The clarity brought by a recovery orientation and abstinence criteria and outcomes went a long way to beginning to resolve the problems of reputation and lack of clarity about the purpose of community rehab.

When the community rehab focus was only'engagement' as the highest value, there were no clear endings and markers of success. The experiments with abstinence outcomes in 2006/7 showed that it might be possible for more people to become abstinent entirely in a community rehab setting.

A recovery orientation reminded us we were here to help people get better. The abstinence criteria emerged from the acknowledgement of the best conditions in which to launch a recovery journey. We moved from being dominated by subjective criteria only(what does the programme participant want to achieve) to having at least one plank of objectivity (abstinence and attendance) to work with in the referral and assessment process.

Abstinence outcomes and criteria led the SEA team to be clear about interventions they were making and what they were trying to help individuals achieve. It meant SEA was clear about

what it was contributing to the individuals recovery journey and what it could not do. It could not act as place to establish abstinence, it could develop that abstinence once it had been established in CAT. This meant also that we were clearer about what we expected from the CAT and they knew what was expected of them in referrals.

At our graduation ceremonies, for a year we awarded a bunch of flowers to the strongest CAT referrer in the last few months. We gave positive feedback when we saw it happen. We thanked the CAT workers at reviews for the business. We called the CAT Care manager with regular updates from the point of their referral being accepted on programme. We built CAT relationships one at a time, person by person.

Action on Referrals and Outcomes 2008/09

New administration in SEA meant that we cleaned up the data quality . In 2009 we began to get feedback that for the first time there were no quality issues with our data returns.

Our monitoring group explored referrals from GDCC/ HAT/ GAMH/ LINK UP and other homeless and crisis led services and came to the conclusion that it was not fair to keep accepting referrals when we knew that no-one referred in that way was actually sticking to the programme. We decided to discourage them. We had a clear contract made between ourselves and the local CATS. This made clear what our responsibility is and what is the responsibility of the referrer.

The CAT/ SEA Working Contract

1. Regular updates given by SEA key worker to CM by phone or email on participants progress (not just problem based conversations!)
2. Attendance at Reviews and baseline paperwork from CM.
3. Feedback to CAT Senior Management on referrals from CAT - followed up in S/CAT supervision.
4. Any conflicts (no matter how small) between teams dealt with quickly by management.

Referrals 2008/9

This year referrals hit an all time high of 511. The two teams of the local South/ SE CAT referred a total of 307 people that year. Other/ self referrals ran at 158. The ratio of women to men was also improving.

In this year the daily visit programme was initiated. This allowed a daily one hour slot for Care managers to book in their referrals for a project presentation. All assessments were being carried out within a week of the initial visit.

The Staff team at SEA were designing themselves for capacity. They were given clear guidance on top workloads and had some admin tasks like bus fare management taken off them to allow them to concentrate exclusively on delivering groups and 121's consistently.

Self and other referrals again

It was in this year that we began to see the wheat from the chaff in terms of referrals. With a clear recovery orientation and higher demands being placed on programme participants. it became clear that many of the self referrals were not ready for this rigor. The programme was not 'just something to do'. The community rehab was repositioning itself on the recovery continuum. It wanted to be a part of treatment system exits. It saw that it could offer helpful recovery based exit programmes to the treatment system. It did mean that if the person was not able to get a few days abstinent, they really were not ready to begin our programme. Many of the self referrals said they met the criteria but didn't show up even for the visit. Many of those from homelessness and crisis services said they wanted a programme in the community but only a handful ever made it back alone after their accompanied visit.

We took the decision , with our monitoring group, to go back to the basic contract requirement: that every referral has a CAT care manager. We went one step further; that every referral has to be made by the CAT care manager.

Where the CAT care manager has made an assessment of the person's needs and has discussed the options available and selected the Community Rehab intervention jointly with the client, we found the highest sticking rates to the new recovery focussed programme.

Indeed, where the CAT care manager stays involved in the review and feedback process we could see that their clients had much improved abstinence rates on our programmes. This became clear when we started getting more referrals from CATs outside the South/ SE area.

Where these non South Care Managers, unused to the level of relationships and contact, didn't answer their phones, return emails or contribute to reviews, we saw their clients had less chance of sticking to the programme during any difficult phase in their recovery process.

South CAT Care Managed clients routinely did and still do perform better on the SEA programme, mainly because of their adoption of the idea that we are all part of the programme participants recovery team.

Critically it also meant that if the programme at SEA didn't help a person, they still had an active involved Care Manager to fall back on. We began the process of stopping the self referrals. We were also prepared to refuse referrals from CATs outside South who were not fulfilling their part in the shared contract.

In 2009/ 2010, Self / other non CAT Referrals ,dropped to 84 out of 451 total referrals . In 20010/11 they became an obsolete 3 in a total of 337 referrals for the year.

Referrals 20010/11: SEA Capacity achieved and maintained.

Referral dropped in 2010/11 to a total of 337. We can see the largest part of that was the loss of those self referrals which never proceed past self referral to take up of programme. So no loss, just clearer use of the time for the people who were appropriate for the recovery service.

Referral total numbers are no longer the main measure of either the effectiveness of the service or its relationships with CATs. Though they are still significant in their steady stream of people coming from CATs into SEA Recovery programmes. The use of Community Rehab in the south is now a viable alternative for recovery outcomes to residential rehab.

Now we see that effectiveness focus moved to the **outcomes** of the recovery programme. We see those outcomes in abstinence rates, attendance rates, taking up community recovery meetings in addition, employability goals met. The focus for the effectiveness measure is now on the number of programme graduates.

In 2010/11 the SEA programme hit its capacity. It held 80 individuals on its recovery programmes at any one time. Most of those individuals were on day programmes; from 7 hours weekly in Phase 1 and 3, to the 11 hours minimum weekly contact of Phase 2. We held a number of individuals in evening group only support too. We held about 6- 10 people in The Blue and Green methadone group which was later replaced by Recovery Night School to include those with alcohol recovery journeys.

By January 2012 we have had 255 graduates of the Phase 2 and 3 programmes since that first graduation in Sept 2007. In Sept 2011 one of our first 2007 graduates achieved the 5 year of recovery mark (and is now a full time employee in a Community Rehab).

The relationships with CATs are now more effectively measured in our ready willingness to enter into joint projects. South CAT co-sponsor the Blue and the Green programme. SEA and CAT staff jointly facilitate this weekly methadone withdrawal support group. The Recovery Night school is likewise jointly led. Indeed from April 2012, the CAT will lead this themselves in SEA premises with a recovery volunteer from the programme. SEA and CAT staff are equally involved in the South Recovery networks and supporting initiatives like RAFT.

Graduations are still where we all come together with participants , family members and friends and quietly but regularly celebrate all of our contributions to recovery in the community.

Graduate outcomes- 2011

The crowning glory for me of both the clean up of the SEA data quality, the SEA recovery programme and the transfer to treatment outcomes not engagement as measures of success comes in the programme completion chart of 2011. It has taken almost five years of work to achieve what the commissioners of the original community rehabs hoped they could achieve.

The Achievements 2011

348 referrals.

Two thirds (222)of those referred make it to assessment processes.

More than half (133) of those making it to assessment actually take up their programme place.

Half of those taking up the place, successfully complete the one month phase 1. 71 individuals in 2011.(10 days abstinence/ 70%attendance, ability to use groups and 121's to change their addiction behaviour)

Two Thirds of these go on to successfully complete the four month phase 2 . 59 Individuals.(8 weeks abstinence, 70% attendance, clear use of recovery tools and community recovery to maintain abstinence, part of employability process)

Half of these go on to successfully complete the 6 month phase 3 programme . 26 individuals.(90 days abstinence, recovery community action, 70% attendance, employment/ education/volunteering actively, plan for long term recovery in the community)

26 people a year successfully complete a year long treatment programme and exit the system. SEA and South CAT are combining successfully to provide recovery exits for people involved in the treatment system.

Those 26 Phase 3 graduates are the cherry on the recovery cake. Every four months we add more to the total number of SEA graduates. Each phase in the programme is a contribution to recovery in itself and can be used on its own. The year on year growth in this graduate community has added substantially to the reputation of SEA. We don't need to do service promotion work, that is done for us by satisfied graduates and care managers. To date we have :

173 Phase 2 graduates

82 Phase 3 graduates

The farmers and the cowhands have surely become friends and the benefits have been clearly felt by the programme participants and the communities we both serve. South Glasgow is now fast becoming a recovery "HOT SPOT" for Scotland. This work of steady relationship building and working jointly on exits from treatment has made for a new phenomena: CAT/ Community Rehab teams that actually like and respect each other's contribution to recovery. 180 degrees of change in relationship over five years,

Dh Kuladharini

Service Manager

South East Alternatives

May 2007- March 2012

For Kelly, John and Caroline with gratitude.

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